

**GEORGIA BOARD OF REGISTERED PROFESSIONAL NURSING**

237 Coliseum Drive  
Macon, Georgia 31217

**VERIFICATION OF EMPLOYMENT**

**Instructions:**

1. Applicant: Complete Section I and sign.
2. Submit this form to all nursing related employers in the 4 years preceding this application (Personnel Director, Human Resources Department) that can provide verification of your practice as a registered nurse. Ask the employer to complete the form and place it in a sealed envelope by them for you to be submitted with your application.

**Section I (To be completed by applicant)\*The name and address of your employer on this form must match the name and address you listed under "Nursing Related Employment" on the application.**

**Section I:**

Printed Name of Applicant: \_\_\_\_\_  
Last
First
Middle
Maiden

Applicants Address: \_\_\_\_\_  
Street
City
State
Zip Code

**RELEASE:** I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Registered Nursing. I understand this information is required as part of the application for licensure process.

Signature of Applicant \_\_\_\_\_ Applicant Phone Number (s) \_\_\_\_\_

**APPLICANT – DO NOT WRITE BELOW THIS LINE:**

**Section II (To be completed by person verifying employment):**

**Instructions:**

1. Complete Section II of this form.
2. Registered Nursing employment must have been for compensation.
3. Each Title held with one employer requires a separate verification form completed.
4. Return the form to the applicant.

1. Name of Facility/Business/Employer: \_\_\_\_\_ Phone Number: (     ) \_\_\_\_\_  
 Is this a federal agency of the United States Government? ☐ No Yes ☐

2. Physical Address of Location: \_\_\_\_\_  
City
State
Zip

3. Employee's Position/Title: \_\_\_\_\_

4. Is an RN license necessary for employment in this position? ☐ No Yes ☐

5. Is an APRN authorization necessary for employment in this position? ☐ No Yes ☐

6. Identify the Actual Physical Location where the employee practiced to include facility name, city/state if different than # 2 above or indicate same as above:  
 \_\_\_\_\_

7. Employment Dates: From: \_\_\_\_\_ (mo/yr) - To: \_\_\_\_\_ (mo/yr)  
 Were there any periods of extended absence during employment? ☐ No Yes ☐ Please provide dates \_\_\_\_\_

**LIST BELOW THE NUMBER OF HOURS WORKED PER YEAR AND Job Description: List below the number of hours worked per year and duties:**

Year	Hours worked	Job Description

8. Printed name and title of person verifying employment: \_\_\_\_\_

9. Signature/Date of Employer Representative completing this form: \_\_\_\_\_ Date \_\_\_\_\_

(Employer Signature/notarization valid only if occurring on same date.)

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Notary Public Signature \_\_\_\_\_ (Notary Seal)

My commission expires: \_\_\_\_\_